DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G031	A. BUILDING _____ B. WING _____	R 03/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI-SERVICES, INC	4314 9TH STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS A revisit survey was conducted on March 17, 2009. The Plan of Correction for the August 21, 2008 recertification survey, which was submitted by the facility on September 15, 2008, was the focus of this revisit survey. The facility was providing services and supports for six women with various disabilities. The findings of this survey were based on observations, interviews with staff and clients in the home, as well as a review of client and administrative records, including the incident management system.	{W 000}	GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, during the follow-up survey on March 17, 2009, the governing body failed to exercise operating direction over the facility as evidenced below: The findings include: [Cross refer to W331] The Governing Body failed to ensure that it's Procedures for Medication Administration were implemented as written to prevent a medication error for Client #1. The review of unusual incidents on March 17, 2009 at approximately 11:30 AM, revealed that on October 28, 2008, at 6:15 AM, Client #1 was administered Client #4's morning medications by the medication nurse. The corresponding	W 104	Nursing staff will receive training on procedures for medication administration.	4/24/09

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Constance C. Reese — Program Director — 4/14/09

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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W 104	Continued From page 1 investigative statement documented that the client was closely monitored and remained lethargic until approximately 3:30 PM on that day. A nursing progress note written by the evening medication nurse on October 28, 2008 at approximately 5:30 PM revealed that the client was up and about, minimally lethargic, had slurred speech, and tolerated her evening meal. The evening medication nurse also documented that Client #1's evening medications were held and that the supervisor would be notified. Interview with the Director of Nursing on March 17, 2009 revealed that the agency had a written "Procedure for Medication Administration" which provided guidelines to the medication nurse and the staff. The review of the Procedure for Medication Administration revealed the following steps steps should be implemented. a. The nurse must ...Administer the medications per physician's order. ...Prepare each client's medication and administer it before preparing for the next client ...Request assistance from group home staff b. Group home staff must... ..Bring one client at a time to the medication room and remain with the client until the medication is administered. There was no evidence the facility ensured its Procedures for Medication Administration were implement as written. The evidence revealed that the failure to implement the Procedures for Medication Administration as written, resulted in	W 104		

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W 104 {W 322}	Continued From page 2 Client #1 receiving Client #4's morning medication on October 28, 2008. 483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure recommended laboratory assessments were obtained timely for one of three clients in the sample. (Client #2) The findings include: On March 17, 2009, at approximately 2:15 PM, review of Client #2's physician's orders (POs) revealed a November 26, 2008 order to "Monitor Prolactin Level". Further record review revealed a December 29, 2008 physician's order which stated "Prolactin Level every 6 months" Interview with the Qualified Mental Retardation Professional (QMRP) on March 17, 2009 at 2:35 PM, revealed there were no Prolactin levels on file for Client #2. Further interview with the QMRP indicated that she would follow-up with the Director of Nursing to determine if Client #2's Prolactin level had been assessed as prescribed. Subsequent review of Client's #2's medical record on March 17, 2009 failed to evidence that the client's Prolactin level had been assessed. It should be noted that on September 8, 2008, the pharmacist conducted a quarterly review, during which he recommended that the client have a "Prolactin level every 6 months. At the time of the	W 104 {W 322}	The Prolactin level for Client #2 was completed on 4/2/09. In the future, the primary nurse will review physicians's recommendation for follow-up tests, pharmacy review and other consultants recommendations on a monthly basis. The Director of Nursing will review clients medical records on a quaterly basis.	4/24/09

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{W 322}	Continued From page 3 survey, there was no evidence the client had received the recommended and prescribed laboratory test to assess and monitor the client's Prolactin level.	{W 322}		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of two of three clients in the sample. (Clients #1 and #2) The findings include: 1. [Cross Refer to W368] The facility nursing services failed to ensure that established Procedures for Medication Administration were implemented to prevent a medication error for Client #1 as evidenced below. The review of unusual incidents on March 17, 2009 at approximately 11:30 AM, revealed that on October 28, 2008, at 6:15 AM, Client #1 was administered Client #4's morning medications (Topamax 100 mg and Zyprexa 10 mg) by the medication nurse. Interview with the Director of Nursing on March 17, 2009 revealed that the agency had a written "Procedure for Medication Administration" which provided guidelines to the medication nurse and the staff. The review of the "Procedure for Medication Administration revealed the following steps steps should be implemented:	W 331		

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W 331	Continued From page 4 a. The nurse must ...Administer the medications per physician's order ...Prepare each client's medication and administer it before preparing for the next client ...Request assistance from group home staff b. Group home staff must... ..Bring one client at a time to the room and remain with the client until medication is administered. The review of a the medication nurse's written statement dated October 28, 2008, revealed that both Client #1 and #4 were at the medication room when the medication error occurred. A staff summary, dated October 29, 2008, was also completed for the investigation of the medication error. The staff wrote that she sent Client #4 in the direction of the medication room, then went to the third floor and escorted Client #1 to the medication room. The staff noted that when she arrived at the medication room with Client #1, she discovered that Client #4 had gone back to her bedroom, instead of the medication room as instructed earlier. Further review of the statement written by the staff revealed that she was not in or at the medication room when Client #1 received the medication from nurse. The staff noted that when she arrived back at the medication room with Client #4, Client #1 was observed with an empty medication cup and was drinking water. According to Procedure for Medication Administration, the staff the should bring one client at a time to the medication room and remain with the client until the medication is administered. There was no evidence that the	W 331	The nursing staff received training on medication error and documentation. The primary nurse will review the MAR on a weekly basis to ensure that the nursing staff are following established procedures for medication administration. 3/24/09 The Director of Nursing will review the individuals medical record on a quarterly basis. 4/24/09	

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W 331	Continued From page 5 nurse prepared each client's medication and administered it to the client before preparing for the next client,or requested assistance from group home staff to ensure Client #1's morning medications were administered without error. At the time of the survey, there was no evidence that the facility' nursing services ensured that the established Procedures for Medication Administration were implemented. 2. The facility's nursing services failed to timely verify that Client #1's medication error was accurately documented: The review of unusual incidents on March 17, 2009 at approximately 11:30 AM, revealed that on October 28, 2008, at 6:15 AM, Client #1 was administered Client #4's morning medications (Topamax 100 mg and Zyprexa 10 mg) by the medication nurse. The QMRP's incident statement documented that the client remained lethargic throughout the day, refusing breakfast and lunch. According to the written statement by the AM medication nurse, dated October 28, 2008, the aforementioned medication error was immediately reported to the nursing supervisor. The medication nurse's written statement further documented that she was informed by the nursing supervisor of the primary care physician's directive to hold Client #1's prescribed morning medications (including Fluoxetine HCL 40 mg for behavior). The medication nurse's statement documented that she held Client #1's Fluoxetine HCL 40 mg as directed. The review of the medication administration record (MAR) for October 28, 2008, however	W 331		

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W 331	Continued From page 6 revealed that all of Client #1's morning medications (which included Fluoxetine HCL 40 mg) were initialed as having been administered to the client. The review of the October 28, 2008 MAR revealed that Client #1's evening medications (except lactulose and Rivia 25 mg), were circled as having been held. At the time of the survey, there was no evidence documentation on Client #1's MAR substantiated that her morning mediation were held on October 28, 2008, in accordance with the PCP's verbal directive. 3. The facility nursing services failed to ensure Client #2 was referred to the laboratory for a Prolactin assessment as prescribed by the primary care physician. (See W322)	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medication was administered without error for one of three clients in the sample. (Client #1) The finding includes: On March 17, 2009 at approximately 11:30 AM, the review of an unusual incident report dated October 28, 2008, revealed that a medication error occurred at 6:15 AM, when Client #1 was administered Client #4's morning medications (Topomax 100 mg and Zyprexa 10 mg). Subsequent interview with the Qualified Mental	W 368	Cross reference W322	4/24/09

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W 368	Continued From page 7 Retardation Professional and the review of the client's medical record on March 17, 2009 confirmed that the medication error occurred. There was no evidence the facility ensured that each client's medication was administered without error.	W 368	Cross reference W331	3/24/09

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{R 000}	INITIAL COMMENTS A revisit survey was conducted on March 17, 2009. The Plan of Correction for the August 21, 2008 recertification survey, which was submitted by the facility on September 15, 2008, was the focus of this revisit survey. The facility was providing services and supports for six women with various disabilities. The findings of this survey were based on observations, interviews with staff and residents in the home, as well as a review of resident and administrative records, including the incident management system.	{R 000}		
{R 125}	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and the review of personnel records, the GHMRP failed to obtain criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years, prior to the check for two of the seven staff employed by the facility. The findings include: On March 17, 2009, at approximately 4:00 PM, the Qualified Mental Retardation Professional (QMRP) provided criminal background documentation requested for review. The subsequent review of the presented information	{R 125}	All criminal background checks will be obtained and placed in their personnel records. In the future, new employees will obtain all required criminal background checks upon starting work.	4/24/09

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{R 125}	Continued From page 1 revealed the following: There was no evidence of comprehensive criminal background check for direct support staff S7 . A District of Columbia background check dated February 5, 2009 was documented for S7. Her personnel records indicated that she was employed by the facility on February 10, 2009. The review of the criminal background check revealed that S7 resided in Maryland. At the time of the survey there was no evidence that a background check had been obtained for Maryland. 2. There was no evidence of a timely and comprehensive criminal background check for direct support staff S1. Review of direct support staff S1's personnel record on March 17, 2009, at 4:05 PM revealed no documentation was available to verify that a background check was conducted. Note: her employment application form, signed and dated on April 3, 2008, listed one former employer with telephone number which included a 347 area code. Additionally, the review of the criminal background check submitted post-survey (dated 3/18/09) revealed it was only for the District of Columbia. Review of this criminal background check revealed S1 resided in Maryland. At the time of the survey, there was no evidence that a background check had been obtained for Maryland or for the area of prior employment (Area Code: 347). (This is a repeat deficiency from the August 21, 2008 Survey.)	{R 125}		

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(R 125)	Continued From page 2 Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check for two of the seven staff employed by the facility. The findings include: On March 17, 2009 at approximately 4:00 PM, the Qualified Mental Retardation Professional (QMRP) provided criminal background documentation requested for review. The subsequent review of the presented information revealed the following: 1. There was no evidence of comprehensive criminal background check for direct support staff S7 . A District of Columbia background check dated February 5, 2009 was documented for S7. Her personnel records indicated that she was employed by the facility on February 10, 2009. The review of the criminal background check revealed that S resided in Maryland. At the time of the survey there was no evidence that a background check had been obtained for Maryland. 2. There was no evidence of a timely and comprehensive criminal background check for direct support staff S1 . Review of a direct support staff personnel record (S1) on March 17, 2009 at 4:05 PM revealed no documentation was available to verify that a background check was available. Note: her	(R 125)		

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{R 125}	Continued From page 3 employment application form, signed and dated on April 3, 2008, listed one former employer with a telephone number in the 347 area code. Additionally, the review of the criminal background check submitted post-survey (dated 3/18/09) which was revealed it was for the District of Columbia. Review of this criminal background check revealed S1 resided in Maryland, At the time of the survey, however, there was no evidence that a background check had been obtained for Maryland or for the area of prior employment (Area Code: 347). This is a repeat deficiency from the August 21, 2008 Survey.)	{R 125}		

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{I 000}	INITIAL COMMENTS A revisit survey was conducted on March 17, 2009. The Plan of Correction for the August 21, 2008 recertification survey, which was submitted by the facility on September 15, 2008, was the focus of this revisit survey. The facility was providing services and supports for six women with various disabilities. The findings of this survey were based on observations, interviews with staff and residents in the home, as well as a review of resident and administrative records, including the incident management system.	{I 000}		
{I 090}	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, during the March 17, 2009 survey, the GHMRP failed to maintain the interior of the facility in a safe, clean, orderly, and attractive manner . The findings include: On March 17, 2009, beginning at 6:05 PM, observation of the environment revealed the following deficiencies: 1. One of the three trash cans in the back yard was observed to have approximately 2/3 of the lid torn off, exposing jagged plastic edges.	{I 090}	1. The trash can with the torn lid will be replaced. 2. The railings' vertical supports will be repaired and monitored weekly for disrepair.	4/13/09 4/29/09

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{I 090}	Continued From page 1 2. The railing on the left side of the stairs was missing a vertical support. Interview with the Qualified Mental Retardation Professional (QMRP) during the observation revealed that she was informed that some repairs had been made to the vertical supports of the stairs. At the time of the survey, there was no evidence that the repairs had been completed.	{I 090}		
{I 206}	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that annual health certificates/ inventories was obtained for one of the seven direct care staff. The findings include: Interview with the Qualified Mental Retardation Professional on March 17, 2009, at 1:05 PM revealed that several direct care staff had been recently hired to work at the group home. Review of the personnel records on March 17, 2009 at approximately 3:45 PM revealed there was no health certificate available for S6.	{I 206}	**All annual health certificates will be obtained and placed in their personnel records. In the future, all employees' personnel records will be checked by Residential Manager monthly for current health certificates.**	4/24/09

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	HFD03-0052	A. BUILDING _____ B. WING _____	R 03/17/2009

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I 379	Continued From page 2	I 379	**In the future, the QMRP or Resid-ential Manager will report all allegations of abuse incidents to the Department of Health with-in 24hrs. Fax confirmation sheets to DOH will be attached to the Investigation Report.**	**4/7/09**
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on the onsite review of incident reports, review of reports submitted to the Department of Health, and interview conducted at the with staff, the GHMRP failed to notify the Health Regulation Administration of an allegation of abuse for one of the six residents living at the facility. (Resident#4) The finding includes: Review of the facility's incident reports and corresponding investigations on March 17, 2009 at approximately 1:40 PM revealed the following: On November 17, 2008 at approximately 3:00 PM, the group home's program director was notified by a day program staff of an allegation of abuse, involving Resident#4 while she was at a day program. According to the incident report, a day program staff alleged that a group home staff person was observed punching Resident#4. Interview conducted with the facility's Qualified Mental Retardation Professional (QMRP) on	I 379		

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I 379	Continued From page 3 March 17, 2009, at 1:50 PM revealed that the incident was investigated by the group home. Further interview with the QMRP revealed that the program director had further investigated the incident, and taken measures to protect the client. Through interview with the QMRP, however, it could not be ascertained that the allegation of abuse had been reported to the Department of Health as required by state law. Subsequent record review revealed the incident had been investigation by the program director. At the time of the survey, however, there was no evidence that DOH had been notified of the allegation of abuse to Resident#4.	I 379		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure nursing services were provided in accordance with the needs of two of three residents in the sample. (Residents #1 and #2) The findings include: 1. The GHMRP nursing services failed to ensure that established Procedures for Medication Administration were implemented to prevent a medication error for Resident #1 as evidenced below.	I 401	Cross reference W331	3/24/09

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I 401	Continued From page 4 The review of unusual incidents on March 17, 2009 at approximately 11:30 AM, revealed that on October 28, 2008, at 6:15 AM, Resident #1 was administered Resident #4's morning medications (Topamax 100 mg and Zyprexa 10 mg) by the medication nurse. Interview with the Director of Nursing on March 17, 2009 revealed that the agency had a written "Procedure for Medication Administration" which provided guidelines to the medication nurse and the staff. he review of the "Procedure for Medication Administration revealed the following steps steps should occur: a. The nurse should ...Administer the medications per physician's ordered ...Prepare each resident's medication and administer it before preparing for the next resident ...Request assistance from group home staff b. Group home staff must... ..Bring one resident at a time to the room and remain with the resident until medication is administered. A staff summary, dated October 29, 2008, was completed for the investigation of the medication error. The staff wrote that she sent Resident #4 in the direction of the medication room, then went to the third floor and escorted Resident #1 to the medication room. The staff noted that when she arrived at the medication room with Resident #1, she discovered that Resident #4 had gone back to her bedroom, instead of the medication room as instructed earlier. Further review of the statement written by the staff revealed that she	I 401		

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I 401	Continued From page 5 was not in or at the medication room when Resident #1 received the medication from nurse. The staff noted that when she arrived back at the medication room with Resident #4, Resident #1 was observed with an empty medication cup and was drinking water. According to Procedure for Medication Administration, the staff the should bring one resident at a time to the medication room and remain with the resident until the medication is administered. There was no evidence that the nurse prepared each resident's medication and administered it before preparing for the next resident or requested assistance from group home staff to ensure Resident #1's morning medications were administered without error. At the time of the survey, there was no evidence that the GHMRP' nursing services ensured that the established Procedures for Medication Administration were implemented. 2. The GHMRP's nursing services failed to timely verify that Resident #1's medication error was accurately documented: The review of unusual incidents on March 17, 2009 at approximately 11:30 AM, revealed that on October 28, 2008, at 6:15 AM, Resident #1 was administered Resident #4's morning medications (Topamax 100 mg and Zyprexa 10 mg) by the medication nurse. The QMRP's incident statement documented that the resident remained lethargic throughout the day, refusing breakfast and lunch. According to the written statement by the AM medication nurse, dated October 28, 2008, the aforementioned medication error was immediately reported to the nursing supervisor.	I 401	**The medication nurse received additional training on Procedures of Medication Administration.**	**3/24/09**

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I 401	Continued From page 6 The medication nurse's written statement further documented that she was informed by the nursing supervisor of the primary care physician's directive to hold Resident #1's prescribed morning medications (including Fluoxetine HCL 40 mg for behavior). The medication nurse's statement documented that she held Resident #1's Fluoxetine HCL 40 mg as directed. The review of the medication administration record (MAR) for October 28, 2008, however revealed that all of Resident #1's morning medications (which included Fluoxetine HCL 40 mg) were initialed as having been administered to the resident. The review of the October 28, 2008 MAR revealed that Resident #1's evening medications (except lactulose and Rivia 25 mg), were circled as having been held. At the time of the survey, there was no evidence documentation on Resident #1's MAR substantiated that her morning mediation were held on October 28, 2008, in accordance with the PCP's verbal directive. 3. The GHMRP failed to ensure recommended laboratory assessments were obtained timely for one of three residents in the sample. (Resident #2) On March 17, 2009, at approximately 2;15 PM, review of Resident #2's physician's orders (POs) revealed a November 26, 2008 order to "Monitor Prolactin Level". Further record review revealed a December 29, 2008 physician's order which stated "Prolactin Level every 6 months" Interview with the Qualified Mental Retardation Professional (QMRP) on March 17, 2009 at 2:35 PM revealed there were no Prolactin levels on file for Resident #2. Further interview with the QMRP	I 401	Cross reference W322	4/24/09

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I 401	Continued From page 7 indicated that she would follow-up with the Director of Nursing to determine if Resident #2's Prolactin level had been assessed as prescribed. Subsequent review of Resident's #2's medical record on March 17, 2009 failed to evidence that the resident's Prolactin level had been assessed. It should be noted that on September 8, 2008, the pharmacist conducted a quarterly review, during which he recommended that the resident have a "Prolactin level every 6 months. At the time of the survey, there was no evidence the resident had received the recommended and prescribed laboratory test to assess and monitor the resident's Prolactin level.	I 401		